INSTRUCTIONS FOR COMPLETING CERTIFICATION FORM FOR ADMISSION TO PSYCHIATRIC INPATIENT CARE

The purpose of the Certification Form is to document the professional's decision regarding the medical necessity for psychiatric inpatient care for an individual. Copies of the completed Certification Form should be kept in the client's hospital record and in the Regional Support Network (RSN)/county management site identified by each RSN. The Certification Form does not have to be provided to Medical Assistance Administration for claims processing. Nevertheless, the Certification Form documents RSN authorization for payment for hospital admission. In order to meet Federal, state and RSN requirements, the following minimal information **must** be included on the Certification Form.

RSN Name and Authorization Code Number: The form must identify the authorizing RSN and the nine-digit code number assigned to each individual claim by the RSN.

Name: Name of client for whom care is being certified

Date of Birth: Self-explanatory

Patient Identification Code (PIC): The code obtained from the medical identification card. It is a fourteen-digit figure. A birthday of January 10, 1960, for John A. Jones would appear as **"JA 011060 JONES A"**.

County of Residence: County where the medical card was issued.

Name of Hospital: Hospital where the admission will occur.

Date of Admission to Psychiatric Inpatient Care: Actual date of admission to the above hospital.

Person Giving Consent to Care: Check one or more of the boxes to indicate the person(s) giving legal authorization for inpatient care. By state law the consent of a minor is not required for admission. Check the **Client** box if the person (age 13 years or older) being hospitalized gives their consent for inpatient care. Check the **Parent** box if the biological or adoptive parent authorizes care for their minor child (age 0-17 years). If the minor also gives consent for care, check both **Client** and **Parent** boxes. If the minor child is over the age of 13 years and does not give consent for care, check only the **Parent** box. Check the **Legal guardian** box if a person who has been assigned guardianship authority gives consent for medical care for the client. The **Other** box allows for additional persons who otherwise have been granted legal authority to consent for care, e.g. parent surrogate, DCFS social worker, Guardian ad litem.

Level of Inpatient Care Needed: Check one box only. Any admission delayed for lack of bed space is not considered to be an emergent admission.

Signatures of Team Members: The required professional(s) must sign and print/type their name and title, and date the form on the same date they sign it.

INSTRUCTIONS FOR COMPLETING LENGTH OF STAY EXTENSION FORM FOR PSYCHIATRIC INPATIENT CARE

The purpose of the Extension Request Form is to document the review of the continued medical necessity for psychiatric inpatient care past the 75th percentile of the Professional Activity Study (PAS) code as listed in the *Length of Stay (LOS) by Diagnosis-Western Region.* The hospital providing care is responsible for initiating an extension request and for completing the top part of the form. The responsible Regional Support Network (RSN) reviews the hospital request, approves or denies additional days of care, completes the bottom of the form and returns it to the hospital. If additional care is authorized by the RSN, the Extension Request Form must be submitted by the hospital with the Medicaid billing form UB-92 to Medical Assistance Administration for claims processing.

The one page Extension Request Form is the standard required format to be utilized statewide. The following information must be completed on each form or claims cannot be processed and will be denied. At their discretion RSNs may require additional information from the hospital in order to make length of stay determinations.

RSN Name and Authorization Code Number: The form must identify the responsible RSN and the nine-digit code number assigned to each individual claim by the RSN.

Name: Name of client for whom care is being certified.

County of Residence: County where the medical card was issued.

Patient Identification Code (PIC): The code obtained from the medical identification card. It is a fourteen-digit figure. A birthday of January 10, 1960, for John A. Jones would appear as **"JA 011060 JONES A"**.

Date of Birth: Self-explanatory.

Inpatient Facility: Hospital where the client is receiving care.

Principal Diagnosis: Descriptive principal diagnosis covering the primary or initial psychiatric hospital stay.

Other Diagnoses: List any other diagnosis codes that will be included on the Medicaid billing form UB-92.

Principal Diagnostic Code: This is the International Classification of Diseases--9th Edition (ICD-9) code for the principal diagnosis.

Date of Admission: Actual date of admission to the above hospital.

Maximum Length of Stay by Diagnosis (PAS days): In the first blank list the maximum number of days allowed according to the 75th percentile of the Professional Activity Study (PAS) code as listed in the Length of Stay (LOS) by Diagnosis-Western Region. In the second blank indicate the date on which the maximum number of days will conclude.

Reason for Extension Request: Provide a complete justification of the reason(s) for the extension request. The responsible RSN makes a decision based on the information provided in this section and on any additional documentation they require. At a minimum the hospital should answer the parenthetical questions.

Number of Extension Days Requested: Indicate in the first blank the exact number of additional days currently being requested insofar as professional assessment can be made. In the second blank indicate the date on which the extension days will conclude.

Hospital Reviewer Signature: The hospital professional completing the form signs and dates the form here.

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Number of Extension Days approved: After review of the required information, indicate in the first blank the number of additional acute inpatient days approved. In the second blank indicate the date on which the approved extension days will conclude.

Number of Administrative Days Approved: If any of the extension days requested by a hospital are determined to not be medically necessary, but continued stay is required to enable appropriate discharge, the reviewer indicates the approval for specific days of care with payment at the lower administrative rate.

Number of Extension Days Denied: If any of the extension days requested by a hospital are determined to not be medically necessary and discharge is recommended, the reviewer indicates the denial of payment for specific days of care.

Authorizing Signature of the RSN: The authorized reviewer signs and dates the form here.

Comments: The RSN reviewer may make comments regarding the extension request.

Form distribution: The hospital submits the partially completed form to the RSN-designated contact point for processing. The RSN returns the completed form to the hospital, retaining necessary copies for RSN use.